David Banes

From: David Banes [dbanes@saipan.com]

Sent: Monday, August 01, 2005 10:59 AM

To: dbanes@saipan.com

Thanks for asking me to help you with this case. As you requested, I have looked a the issue of the femoral fixation and whether that is the cause of "most" of Ms Santos' pain and suffering.

First of all, there are certainly questions as to why Dr Austin chose to rod Ms Santos femur with inadequate fixation on 1/31/04. While it may not be a clear case of malractice, it is not ideal practice. However, the fact that there was some fixation at the fx site after the first nailing was probably better for Ms Sanots overall health than being at bed rest right leg tibial pin skeletal traction for the one week it took to get a more appropriately sized rod. In this sense, perhaps the first rodding was a less uncomfortable and more mobile alternative.

The second rodding on 2/7 /04 did accomplish stable fixation and this ultimately resulted in a solid union of the fracture in very good position and alignment. I do not think the length of rod protruding from the proximal femur is ideal, but it is not excessive or below the standard of care either. Different surgeons leave differing amounts of nail protruding from the bone.

Now that Ms Santos has a solid union of her fracture, the IM rod can be removed in a very low risk proceedure and that should solve her buttock pain problems.

In conclusion, Ms Santos suffered a serious injury on 1/30/04. She underwent a first surgical proceedure with a less than optimally sized implant which did not fully stabalize her fracture, necessitating a second operation one week later with different sized hardware that did lead to a successful outcome. There is no doubt that the majority of Ms Santos pain and suffering were the result of her femoral fracture and the treatment required to support and transport her post injury as well as gain healing of the bone, not the short nail in the first instance or the somewhat prominent proximal aspect of the nail in the second. Had Ms Santos not fractured her femur, no transportation or surgical treatment would have been required.

I hope this is helpful.

JLC

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Hofer Clinic **Phone: (671) 734-0382; FAX 734-0393**
Pamina J. Hofer, Ph.D.; Clinical Neuropsychologist P.O. Box 5208, University of Guam Station
Dr.pamina@hofer.com Mangilao, GU 96923

Preliminary Report of PSYCHOLOGICAL ASSESSMENT

Client Name: Mrs. Elenita Santos
D.O.B.: August 7, 1955
Age: 49 years
Date Interviewed and Tested: April 22, May 6, 18, June 23 & 25, 2005

Referred by: Attorney David Banes
Responsibility: O'Connor Berman Dotts & Banes
Gender: Female
Date of Report: June 25, 2005

Reason for Referral:
Mrs. Elenita Santos was referred for a psychological evaluation by her attorney, David Banes.

The following information is only a preliminary report, and was obtained by interviewing and testing Mrs. Santos, and interviewing her daughter, son, and husband during their multiple visits with Dr. Hofer on the above-noted dates at Hofer Clinic, Guam. The interview and testing were conducted in English, which is the client's second language. She and her husband primarily speak Chamorro, but she is conversant in English. Her children (daughter and son) assisted in explaining questions about which she was unsure to her. She provided all answers to the examiner herself, in English.

Other materials interviewed/reviewed:
- No medical file materials reviewed at this time

Observations:
Mrs. Santos presented as a neat, clean, and attractively groomed, 70-year-old, pleasant, Chamorro woman. Her dark brown hair was neatly combed on all occasions, and she appeared to have just come from the beauty parlor (with a lovely perm) on June 23, 2005. Mrs. Santos seemed significant stressed at the time of the first evaluation. When questioned about the reason, she indicated she "still have pain" and indicated it is the worst in her right hip and back.

Mrs. Santos seemed very willing to participate in the evaluation, and arrived on time for her appointments with Dr. Hofer. She spoke readily about her educational history, and number of children, then (initially) had difficulty when she was asked to talk about the situation that had occurred and the Tinian Dynasty which caused injury. "I try not to think about it," she said of that fall. She appeared to describe her feelings after her injury, and her continuing fears since the accident openly and honestly, but she noted it "drain(ed) me". She seemed disheartened by the fact that her ankle pain was continuing, and was very upset by the fact that she might have to have another (third!) operation in order to correctly place an appropriate pin in her right leg. During her therapy visit (May 18, 2005), she appeared to find it slightly easier to describe her current condition, and told the examiner she appreciated having the opportunity to speak at length with someone about her condition. When alone with the examiner, she related feeling she didn't want to live at times. She cried and was very upset with herself for ". . .even thinking like that", but she added, "I just can't go on like this." She explained her pain and memories of being terrified were each extreme.

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To date, Mrs. Santos has, primarily, discussed the decision that looms before her - of choosing whether or not to have another operation. This single decision has been traumatic for her, and she has felt very confused by the positive and negative aspects involved. "I can't get my head clear" she told the examiner on May 18, 2005. Ways of clarifying her options were discussed in therapy, and her daughter (who accompanied her that day), assisted by including information about the supportiveness of her family - regardless of her choice.

Mrs. Santos seemed better, physically, when last seen (June 23, 2005). By that time she had obtained pills from her physician that helped her gain a full night's sleep. Still, as we began to discuss her pain, she became shaky and cried, that, "I just want it over!". She noted that "Nowadays, if somebody hurt, I feel it", and went on to explain her pain is "always there" but she can disregard it a bit until she hears about someone else's physical or emotional pain: Then her own pain becomes prominent in her mind and she has to stop whatever she's doing. She also indicated she was still very fearful, especially when alone (even momentarily) or attempting to walk down stairs. She described having flashbacks, ". . .exactly like I was there" (just after she had fallen at the Tinian Dynasty). She also continued to worry about the pain, because "Dr. Kamalan's office was supposed to call" about the recent X-ray. Hofer Clinic followed up on this latter issue, and found Dr. Kamalan's office has not yet received a report of her X-ray results.

During her interview with Dr. Hofer, her speech was fluent, prosodic, and without intrusions or stuttering. She would pause after questions and statements, at times, however. Sometimes, she had to pause as she cried. When asked if she needed a break, she would shake her head and say, "Just a moment". Her thought content was logical and coherent. As she relaxed in the environment, she also seemed very open, frank, and willing to describe her accident, family life, and pain problems, with this examiner.

Mrs. Santos feels her terror (which sometimes hits her now without warning) is currently her greatest difficulty. She noted she sometimes feels ". . .just like then, at the bottom of stairs, with no one coming" - even though she cried for help. She also described having trouble with "constant pain" from her right side/hip/back. She agreed she has trouble concentrating, memory, understanding others, and being far more sensitive to criticism since the pain condition began when she broke her leg. She also noted, in comparison to her personality prior to her injury of last year, she is more hopeless, irritable, anxious, and tired. She noted she had never before felt suicidal, but since the accident she's often felt "other people would be better off without me". When queried, she had no intention of taking her own life, rather, she often wishes she could ". . .just lay down and die".

In my opinion, Mrs. Santos was cooperative, motivated, and very sincere in her attempts to perform to the best of her ability the tasks placed before her by the examiner. Moreover, she seemed diligent – even though she was asked to discuss topics that were emotionally very difficult for her.

Since she seemed to work to the best of her ability on all tasks, I believe the following results are an accurate reflection of Mrs. Santos's current level of cognitive and emotional functioning.

TESTS ADMINISTERED & PRELIMINARY RESULTS

Clinical Interview
Battery for Health Improvement
Brief Symptom Inventory (May 6, and May 18, 2005)
Pain Patient Profile (P-3)

Health Status:

Pain Patient Profile (P-3): *This measure is designed to provide screening to determine the presence of psychological variables associated with pain and their influence on pain symptomatology. Pain is a multidimensional phenomenon composed of physiologic, psychological, and other influencing variables. Factors such as depression, anxiety, and excessive somatic thought are specifically identified in the medical literature as actively contributing to the etiology, maintenance, and intensity of pain. When these factors are appropriately identified and clinically addressed, treatment outcomes resulting from nonsurgical, surgical, and rehabilitative interventions are significantly improved.*

Factors such as depression, anxiety, and excessive somatic thought are recognized as actively contributing to a patient's perception of pain. Further, a patient whose pain is influenced by psychological variables may not have the emotional readiness necessary to be successful in a physical treatment program – including surgical interventions.

This measure also allows the individual's scores to be compared with those from persons with true, well-documented and long-standing pain disorders who continue to live in the community. Thus, an objective measure of the reasonableness of her pain sympatomatology can be obtained. Persons who exaggerate or feign pain disorders can quickly be identified.

Mrs. Santos's score on the Validity Index suggests she was able to read the items appropriately and attend to item content. It appears that she approached the test in an open and honest manner. Her score suggests the results can be interpreted with confidence.

Mrs. Santos's scores on this measure show her Anxiety is in the Average range for pain patients – even though it is ***very*** elevated in comparison to scores on similar questions obtained by other women her age.

Thus, according to this measure, she is not exaggerating or feigning deficits. Rather, she is experiencing symptoms of anxiety in the normal range when compared with other patients with long-term pain. Her other symptoms are consistent with increasing difficulty managing her pain disorder. Please note: This test was done before she was given medication that enabled her to sleep. She felt she was only able to sleep an hour or two, and then she would awaken because of the pain in her right hip and back.

Mrs. Santos's Depression score suggests that she is more depressed than the average person her age is – even when compared with pain patients. Sleep and appetite disturbances were prominent, and her difficulty sleeping was considered fundamental as part of her depression. She has not yet repeated this measure since she has been taking medication that enables her to sleep. However, even though she is sleeping better, she is likely described by others as "sad", "lethargic", "apathetic", "listless", and "aloof". She cries whenever any aspect of her pain or recollection of her accident is brought to mind, and she is very embarrassed by showing her emotions. She is feeling distressed, drained, and emotionally burdened by the duration of her discomfort and the impact of her problems on her ability to function.

Health Status:
Pain Patient Profile (continued):

Mrs. Santos' depressed condition needs to be addressed as quickly as possible, so that it does not cause further emotional deterioration.

Mrs. Santos's Somatization score is close to that of the average for a pain patient. She is concerned about and attentive to her health-related problems, and somatic issues occupy an undue amount of her attention, as she is frightened both of continuing to live in pain or having to endure the pain of recovery after another operation. Individuals with a clearly defined organic basis for pain often respond in this manner. She feel victimized and angry. Additionally she is experiencing mounting frustration and somatic distraction (interference by her pain with her ability to focus and concentrate). She is cognitively and emotionally distressed by her physical symptoms. Still she has the ability to actively participate in a treatment plan for pain relief.

Although in the average range in comparison to other pain patients, Mrs. Santos reports a number of symptoms of anxiety, agitation, and cognitive distress. Interestingly, this is the symptom (anxiety) which she reports as being "the worst". She feels she is having trouble controlling her anger, and may report being irritated by situations and events that formerly went relatively unnoticed. She is probably not comfortable in social situations, and prefers to avoid them as often as possible (which may heighten and/or maintain her depressive symptoms, as well). She reports feeling irritable, tense, worried, impatient, and upset and she finds it difficult to relax and make decisions. Others may see her as being on edge, somewhat agitated, and somewhat distracted - certainly more so than she was before the accident. These symptoms of anxiety are straining her coping skills. Further, while not unusual for a pain patient, her anxiety symptoms may complicate her symptom perception and response to treatment.

Health Status (continued):
Battery for Health Improvement (BHI)

Mrs. Santos's scores are compared with the ratings of physically injured patients as well as a community sample. The following interpretation is based on comparing her scores with those of community-dwelling patients with physical injuries.

Mrs. Santos's scores on this measure indicate she responded in a valid manner. She did not choose any unusual item responses, and she appears to have understood the test items.

Her scores also indicate higher elevations on Psychological factors (depression, anxiety, and hostility) than most persons involved in a physical rehabilitation program. She is depressed, anxious, irritable, and angry. Although none of these feelings are extreme, there is a pervasive negativism that colors her perceptions and mood. This mixture of emotions can be unsettling, and may leave her not knowing how to respond.

Other women who answer questions as Mrs. Santos are feeling a great deal of anxiety about their present circumstances. This is in keeping with her verbalizations that she is frightened by the situation in which he finds herself (i.e., having to decide whether to endure her current pain or face the pain of another operation).

Health Status (continued):

Battery for Health Improvement (BHI) (continued):

Her scores on physical factors (e.g., pain) is higher than that of the average patient in physical rehabilitation. While her scale scores indicate the pain level she reports is likely very accurate, it also indicates her emotional reactions (anxiety and depression) are increasing her sensation of pain as well as increasing her tendency to focus on her pain.

Mrs. Santos's Symptom Dependency scale is mildly elevated. This indicates she is currently prone to developing intense emotional attachments to loved ones or to medical caregivers. At present, her family members appear to be supporting her decisions, but are 'holding fast' to the idea that she must decide for herself whether to have the third operation or not.

Overall, Mrs. Santos has a positive outlook and an optimistic view of the world. She attempts to take good care of herself, and believes in her ability to overcome challenges. However, she apparently feels overwhelmed by her combination of physical and emotional symptoms together with the decisions she must make about her treatment.

Importantly, she is currently espousing statements that indicate she may be dangerous to herself (i.e., agreeing with "Life has been so hard lately that at times I have wished I were dead" ;and "I have attempted suicide in the past").

SUMMARY

Mrs. Santos is a 70-year-old woman who was involved in an accident last year when she fell walking down steps at Tinian Dynasty hotel where she was staying. She lay crying for help and unable to move for what felt like "forever" but was likely 30 minutes before a Tinian Dynasty staff member found her. Her right leg was broken when she was finally found and taken to the hospital.

Mrs. Santos continues to experience pain even though surgery has been performed. In fact, she has actually had to endure two operations, as a pin of incorrect size was placed in her leg during her first operation. Further, apparently the second pin was also of incorrect size, as she continues to experience pain that awakens her whenever she moves at night. Very recently she was prescribed, and has been taking sleeping pills so that she can sleep through the night. She dislikes "having to take the pill". She can no longer participate in activities she used to enjoy, and she feels hopeless about the future.

Mrs. Santos notes that, with very few and short-lived times, her pain has been continuous and is ". . .often really bad". However, it is the terror of being helpless that flashes back in her mind, and is "the worst" to her. Her appetite, at the time of the examination was described as being "not good", and her sleep was disturbed until she recently began taking sleeping pills.

She cried as she told the examiner she's tired "all the time", and scared "of even little thing". She hates to be left alone or to go anywhere alone, as she tends to relive the incident more frequently (of falling and having no one hear her cries for help) when she is alone. She described a myriad of household tasks in which she can no longer engage.

Mrs. Santos's test scores reveal she is responding in a valid, open and candid manner. Thus, she is neither feigning nor exaggerating deficits. Rather, when her scores on a variety of measures are compared with those of women with diagnosed pain disorders, her anxiety appears within the normal range for an individual with a long term generalized pain problem, except for depression and focus on her physical symptoms (the latter of which is in keeping with her having to decide about another operation). It appears that she is depressed, and she often thinks of harming herself rather than enduring the pain or the imposition she feels she is now on others.

It does not appear that Mrs. Santos had a pre-existing mood disorder or a pre-existing pain condition.

CONCLUSIONS

Mrs. Santos's self report of increasing irritability, anxiety, depression, confusion (especially when forced to make decisions about issues relating to the accident) and continuing pain are a constellation of symptoms consistent with her having fallen, unobserved, and broken her leg. Then, having lain without help for an extended period of time. She also noted that she is having increasing difficulty with anhedonia (not being interested in – even pleasurable activities – in which she used to engage), trouble making decisions, generalized worry.

She is not malingering or feigning deficits, (although her emotional reaction intensifies her physical pain, and the pain decreases her ability to concentrate) as indicated by objective testing, noted above.

Mrs. Santos would likely benefit from therapeutic intervention for her difficulties.

- Psychopharmacotherapeutic intervention is strongly recommended for her pain and depressed mood. If her physician feels an addition in medication is warranted, XENIX is a medication which has been demonstrated extremely effective in alleviating both depressive and anxiety-like symptoms, and may also assist her with her sleep-onset difficulties. Short-term muscle relaxant therapy may also be warranted. I strongly recommend Mrs. Santos be evaluated by a Pain Clinic, as her physical and emotional issues need to be addressed in concert, in order to ensure treatment effectiveness.

- Mrs. Santos needs to decide whether she will have the next operation (for a third pin replacement in her leg). She currently does not have the report (nor does Dr. Kamian's office) about her most recent X-ray. She needs to have all the available information in order to make an informed decision.

- Once she has decided a course of medical treatment, further psychological intervention can be recommended. However, at a minimum, the following is recommended:

- Weekly psychotherapy including relaxation training and cognitive behavior modification, with 90-minute sessions for 3-4 months.

- Family therapy, with at least one family member attending (spouse or child). Mrs. Santos' treatment success will depend, in part, in her family being consistent in their encouragement of

to return to her previous activities. The family members will need help in ascertaining how much 'help' is good for her, and when they should encourage her to do things for herself.

- Weekly 60-minute sessions for 6 months.
- Behavioral treatment, including biofeedback, to help Mrs. Santos learn to alleviate her sense of stress, as stress strongly effects the degree of exhaustion and annoyance she experiences.
- Additionally, participating in regular physical exercise (dictated by a physical therapist) is strongly recommended to assist her return to a stronger, healthier self.

Mrs. Santos may find any or all of the above-noted recommendations beneficial. However, she will likely continue to have 'bad days' due to her pain disorder. She will also likely continue to make errors on even the most basic of tasks, as she has trouble with concentration, and to have bouts of panic, in which she has 'flashbacks' of being alone, helpless, and in pain. Her difficulties will not be consistent, but will vary from day to day, as will her pain.

I have indicated I would provide Mrs. Santos with a list of other Clinical Psychologists on Guam who are capable of providing the above-noted services. While I would be happy to see her in my monthly visits to Guam, another psychologist, who was available to her more often might be preferred.

The above findings and opinions are based on reasonable neuropsychological probability.

Thank you for this interesting referral. If I can be of further assistance on this case, please do not hesitate to contact me.

Sincerely,

Pamina J. Hafer, Ph.D., B.C.E.T.S.
Board Certified Expert in Traumatic Stress
Clinical Neuropsychologist
License #CP-12 (Guam)
License #CP-08 (CNMI)

Curriculum Vitae

ADDRESS & TELEPHONE

PAMINA J. HOFER, Ph.D.
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Mangilao, Guam
USA 96923
(671) 734-0382 or 734-9694
FAX #(671) 734-0393

DATE & BIRTHPLACE — January 15, 1957, Seattle, Washington

CERTIFICATION/ LICENSURE:
1998 — Licensed Clinical Psychologist #CP-12, since 1993
Licensed Clinical Psychologist in CNMI (#8) since 1999
Board Certified Expert in Traumatic Stress; Diplomate conferred by American Academy of Experts in Traumatic Stress

PROFESSIONAL ACTIVITIES & AFFILIATIONS

1997 - present	Credentials accepted for examinations for Diplomate status by **American Board of Professional Psychology; Clinical Neuropsychology**
1999 - present	Full member, **American Association of Behaviour Therapists**
1993 - present	Licensed **Clinical Psychologist** with Guam Board of Allied Health Examiners
1997 - present	Diplomate in **American Academy of Experts in Traumatic Stress**
1996 - present	Full member of **International Council of Psychologists, Inc.**
1995 - present	Full member of **American Psychological Society**.
1991 - present	Full member **World Federation of Neurobehavioural Societies**.
1990 - present	Full member of **American Psychological Association**. Member of Divisions 1 (General), 2 (Teaching), 28 (Psychopharmacology), 35 (Women), 40 (Clinical Neuropsychology), and 52 (International).
1990 - present	Full Member of **International Neuropsychological Society**.
1988 - present	Full member of **National Academy of Neuropsychology** since 1991 (student member 1988-1991).

EXHIBIT D

ACADEMIC BACKGROUND:

1981 - 1990 **University of Manitoba**, Winnipeg, CANADA
APA & CPA accredited clinical psychology program
Clinical psychology, generalist's program with
Neuropsychology and Geropsychology specialities
Ph.D. in Clinical Psychology received 1990 (with honours)
major area: Clinical psychology
minor areas: Neuropsychology, Geropsychology
Ph.D. dissertation: Differentiating Multi-Infarct Dementia from Dementia of the Alzheimer Type: Neuropsychological Test Differences
M.A. received 1985
major area: Clinical psychology
minor area: Geropsychology
M.A. thesis: Volunteer Visiting of the Elderly and its Effects on Loneliness, Self-esteem, and Social Contacts.

1977 - 1981 **Portland State University**, Portland, Oregon
B.Sc. received 1981, with high honours
Major: Psychology
Minor: Biology, Premedicine

1974 - 1976 **Reed College**, Portland, Oregon

PROFESSIONAL EXPERIENCE:

Dec. 1993 - present **Private practitioner, Clinical Neuropsychological Services**
Hofer Clinic (Pamina J. Hofer; sole proprietorship)

Assessment: Clinical Neuropsychological evaluations conducted for assorted institutions, physicians, insurance companies and individuals regarding adults, adolescents, and children. Forensic evaluations, including assessment of Mental Capacity, Criminal Responsibility, Malingering, and Battered Spouse Syndrome conducted for individuals, attorneys, and courts on Guam, the CNMI, and the FSM. Clinical Psychological consultant to Social Security, Guma Mami, and Department of Mental Health and Substance Abuse. Adult diagnostic psychological (including vocational interest and capabilities) and neuropsychological assessments conducted for Department of Vocational Rehabilitation, Government of Guam Retirement, Superior Court of Guam, Worker's Compensation, & Social Security. Percentage disability (in comparison to individual's premorbid functioning) calculated for Govt. of Guam Retirement and Personal Injury cases. Medical (mental health

issues secondary to medical disease or medication use) consultation regarding previously assessed cases of adults, adolescents & children for private and institutional requests (Government of Guam, Social Security, and FHP). Fitness for Duty evaluations conducted for Guam Power Authority, Guam Police Department, U.S. Navy, U.S. Airforce, and private industries on Guam and in the CNMI. Diagnostic consultant for children with suspected learning disability and/or Attention Deficit Disorder. All diagnostic evaluations conducted with emphasis on multicultural concerns/differences. Evaluations conducted with special needs clients (deaf, blind, hemiplegic, and paretic secondary to physical disorder (e.g., Multiple sclerosis, cerebral palsy, stroke, etc.).

PROFESSIONAL EXPERIENCE (cont):

Intervention: Individual child behavioral intervention plans prepared for families, private-, public-, and DoDEA schools. Behaviorally-oriented therapy conducted with special emphasis on trauma victims (I am the only board certified Expert in Traumatic Stress in Micronesia). Consultant to Sanctuary (emergency shelter for troubled youth). Individual therapy for P.T.S.D. and other anxiety disorders; Adult behavioral intervention for Oppositional Defiant Disorder and other disorders of conduct. Behavioral programs created and implemented with children, adolescents, and adults and their families. Treatment of pain disorders, personality disorders, AD/HD, anxiety disorders, trauma history, depression, and substance abuse. Cognitive Retraining for individuals with Post Concussive Brain Disorder. Special attention to multicultural issues in all therapy cases.

Aug. 1993 - May 1997
Aug 1997 - Present "adjunct faculty"

Assistant Professor, Clinical Psychology
Division of Social & Behavioral Sciences & Social Work
University of Guam
UOG Station; Mangilao, Guam
USA 96923

Responsibilities include **teaching** at UOG including undergraduate psychology course & graduate credit courses. Also, teaching at the College of the Northern Marianas under UOG course descriptions including Psychology 101 (Introductory Psychology), Practicum (P459b), Psychology 455/G (Psychology of Women) and Psychology 420/G (Abnormal Psychology) - the latter two offered for graduate credit.

Assistant Professor, Clinical Psychology duties (continued):

Community service, including guest lectures and seminars involving a wide range of topics (e.g., disaster preparedness - earthquake or typhoon survival, time management, what to expect when functioning as a caregiver for elderly parents, handling depression in a loved one or yourself, learning disabilities, traumatic brain injury, psychopathology of people in crisis). Specific instruction on interviewing victims of abuse conducted for Department of Mental Health and Substance Abuse and the UOG Counselling Master's Program. Attended to crises involving air disaster (KAL801; Aug '97); assisted acculturation of Kurdish refugees; and responded to various attempted/post-suicide and post-homicide debriefings. Ongoing **supervision** of psychologists and other health care professionals (e.g., nursing/counselling students and new Clinical Psychologists) for licensure; also supervising teaching assistants and undergraduate Psychology Majors.

Research endeavours include developing standardised assessment instruments culturally appropriate for Pacific Islanders; including participating in gathering normative data for the WISC-IV and developing neuropsychological measures for detecting dementia amongst the Chamorro elderly. **Helped develop Master's Program in Clinical Psychology** with Dr. Iain Twaddle.

Awards:

Who's Who in America (2004)
Who's Who in America's Teachers (1998)
College of Arts & Sciences Service Award (1994-5)
College of Arts & Sciences Service Award (1996-7)

PROFESSIONAL EXPERIENCE (cont):

Jan. 1990 - July 1993

Neuropsychologist (Psychologist II)
Alberta Hospital - Edmonton
Department of Neuropsychology
Box 307, Alberta, Edmonton
CANADA T5J 2J7

Responsibilities included evaluation and interpretation of neuropsychological test data from a wide variety of psychiatric, rehabilitation, geriatric and forensic patients. Referrals include requests for assistance with diagnosis, treatment planning, or assessment of ability to stand trial, and reports include integrated information from neuropsychological and neurophysiological (auditory, visual and somatosensory evoked potentials and 48 channel EEG) evaluations. Duties also include supervision of psychometrists and staff (Ph.D. level) interested in learning neuropsychological interpretation.

A.P.A. & C.P.A. approved Psychology Internship duties:
1992 - 1993, Director of Acute Psychiatry rotation, (including long-term Neuropsychology rotation), Assistant Director of Clinical Internship; & Supervisor of Neuropsychology rotation interns.

I supervised control studies, focused on data acquisition on elderly control subjects for an expanded Halstead-Reitan neuro-psychological test battery. Studies on neuro-psychological correlates of post-traumatic stress disorder - especially in police recruits, test reliability/validity with psychiatric patients, hemispheric lateralization of deficits in schizophrenic and affective patients, use of neuropsychological tests to differentiate Multi-infarct & Alzheimer dementia patients, and use of robust statistics in neuropsychological evaluation and interpretation are in progress.

April 1991 -1993

PAMCO Clinical Psychological Services
Suite 503, 10240 124 Street
Edmonton, AB CANADA T5N 3W6
(Sole proprietor and independent clinical psychology practitioner).
Clinical psychological cases included individual treatment for depression, anxiety, and issues of self esteem. Speciality treatment (socio-behavioral) for eating disorders - especially anorexia and bulimia. Couples/marital therapy and family therapy focusing on issues of communication, contracting, conflict resolution, and sexual dysfunction. Special clinical for children of divorce who were experiencing extreme

distress including disruption of usual school behavior. Family therapy directed at assisting familial communication, adolescent contracting issues, and treatment of adopted (previously sexually and physically abused) children.

Neuropsychological evaluations and follow-up (including program implementation for rehabilitation).

1986 **Consulting Psychologist**
Canada Immigration and Employment
320 Donald Street; Winnipeg, Manitoba
Duties included intellectual and personality assessments, evaluations of readiness for employment and referrals to therapy for chronically unemployed individuals. Also training of job counsellors for group work and preparation (behavioral rehearsal, modelling) for interviews.

1985 **Interviewer**
Committee on Treatment of Obesity
Health and Welfare, Canada; Ottawa, Canada
Interviewed managers of facilities offering "weight reduction" programs in the Winnipeg area. Primary concerns were possible false advertising, low-levels of training in staff, and high cost of such services.

1982 - 1987 **Research Assistant**
Information Service - Psychological Service Centre; University of Manitoba
Involved as member of research team, directed by Dr. Bruce Tefft. Duties included implementing and updating system of data collection for recording number and type of clients serviced by the Psychological Service Centre (outpatient community facility). Duties included data entry, formulating ideas regarding increased user involvement and developing and instituting an outcome satisfaction survey.

1981 - 1987 **Teaching Assistant**
University of Manitoba
Behavioral Control of Obesity; Psychology of Women; Child Psychology; Adolescent Psychology; Abnormal Psychology; Learning; and Introduction to Psychology.
Duties included proctoring and grading exams and handling student concerns (including tutoring). Lecturing from prepared notes occurred in many courses, and personally prepared lectures were delivered for Behavioral Control of Obesity, Psychology of Women and Abnormal Psychology.

SUPERVISED CLINICAL EXPERIENCE:

1988 - 1989 **Neuropsychology/Geropsychology Post Doctoral Studies**
Neuropsychiatric Institute, U.C.L.A.
West Los Angeles, California
Full-time American Psychological Association post-doctoral studies.
Neuropsychology - Supervisors: Wilfred Van Gorp, Paul Satz, and Azenath LaRue

Consultation diagnostic service. Assessment and evaluation using Hypothesis Testing model of neuro-psychological assessment with geriatric population. Cases including probable Alzheimer's disease, Multi-infarct dementia, Parkinson's dementia, AIDS dementia, and acute confusional state. Secondary supervision by to Drs. Benson, and Cummings, in Neurobehavior and Dementia Clinic conferences.

1987 - 1988 **Internship:** *Chief Psychology Intern*
Veterans Administration Medical Center,
West Los Angeles (Brentwood), California
Full-time American Psychological Association approved internship.

Rotations: Neuropsychology -Supervisors: Wilfred Van Gorp, Julianne Fischman and Lynne Steinman

Consultation service. Assessment and evaluation using Hypothesis Testing model of neuro-psychological assessment. Cases consisted of patients with various diagnoses including probable Alzheimer's disease, Multi-infarct dementia, Closed-head injury, Alcohol toxicity, Parkinson's dementia, AIDS dementia, and acute confusional state. Presentation of cases to D. Frank Benson, M.D. and Jeffrey L. Cummings, M.D. in Neurobehavior and Dementia Clinic conferences. Also, weekly training seminars in neuropsychological assessment and interpretation took place at the V.A. Neuropsychology students also developed weekly research meetings. Participation in weekly training seminars at UCLA's Neuropsychiatric Institute including issues regarding neuropsychological assessment and neurobehavioral evaluation.

Geropsychology - Supervisor: Joel P. Abrahams

Case consultant on medical Acute Geriatric Evaluation and Diagnostic ward of medical hospital. Evaluation of gross cognitive functioning, neuro-psychological functioning, and depression with all patients on 35-bed ward. Individual psychotherapy interventions (including behavioral, Gestalt, and client-centered psychotherapy) with patients exhibiting psychological distress occurred. Assistance in life review and death preparation done with patients diagnosed as having terminal cancer. Family support group begun. Also, Case manager for geropsychiatric inpatients. Involved as

multi-disciplinary team leader in assessment and intervention for various psychological and psychiatric disorders (e.g., schizophrenia, depression, mania, bipolar disorder, obsessive-compulsive disorder). Consulted with ward psychiatrist regarding medications, and participated in biweekly or monthly follow up after discharge. Leader and co-leader of therapy groups for seniors, using Object Relations theory. Weekly training seminars in geriatric evaluation and treatment.

Alcohol and Drug Abuse Treatment - Supervisor: William Wells
Individual intake assessments, group psychotherapy, couples psychotherapy, and special group therapy focusing on childhood sexual abuse conducted as part of 30-day inpatient treatment program. Trained patients and their significant others in response prevention techniques.

Long Term Psychotherapy - Supervisor: Lynne Steinman
Twice weekly individual psychotherapy with 38-year-old Vietnam veteran residing in long-term care facility. Psychotherapy focused on assertiveness training, treatment of P.T.S.D., biofeedback training for seizure control, relaxation training for pain control, separation counselling, and anger management.

Chief Intern Responsibilities:
Elected representative of 10 full time and 2 part time interns. Member of training committee, which involved program development (including creation of intern's Supervisor Evaluation form) and conduction of intern's exit interviews at the completion of the internship. Participated in selection of incoming prospective interns. Ambutsperson position assumed in intern's grievance process.

Clinical Work & Supervision during Internship: 1900 hours total.
Supervision: 190 hours individual, 35 hours group.

Training: An additional 500 hours training seminars including workshops in Exner scoring of Rorschach protocols, Human Sexuality, and year-long training seminars in evaluation, diagnosis and treatment of various VA populations. Additionally, audited Dr. A. Caldwell's year-long course on MMPI interpretation.

1985 - 1986 **Clerkship Practicum IV**
Manitoba Clinic
Pediatrics Department
790 Sherbrook Street; Winnipeg, Manitoba

Specialty practicum in pediatric psychology
Supervisors: Marvin Brodsky, Ph.D., Michael Thomas, Ph.D. and Joanne Wersch, M.A.

Consultation with families and children who displayed problems seen by the referring physician as "non-physical" in origin. Focus was on short-term interventions or referrals, but often involved acting as therapist for a dysfunctional family system. A variety of behavioral programs were used for several (relatively common) referrals (e.g., enuresis, nightmares, and aggressive behavior). Child intellectual assessments and analyses of family interaction patterns were also involved. Supervised closely by Dr. Thomas on the hospitalization and re-integration into family of a psychotic child from a low-income, native family background. Family cotherapist with Dr. Brodsky for 2 years in order to stabilise this family unit.

Clinical Work & Supervision: 15 hr/wk (500 total)
Average caseload: 6 families/children per week

Supervision: 1 hour/week individual supervision regarding short-term interventions as well as intermittent live supervision within the interview format with either Dr. Thomas or J. Wersch. Weekly supervision, as well, with Dr. Brodsky, regarding long-term cases.

1985 - 1986

Clerkship Practicum III (Specialty practicum in eating disorders)
Manitoba Obesity Control Clinic
P502 Duff Roblin Building
University of Manitoba; Winnipeg, Manitoba
Supervisor: Michael LeBow, Ph.D.

Individual (adult and child) as well as couples psychotherapy for the treatment of obesity and concomitant emotional difficulties under the supervision of Dr. LeBow using a Systems/Behavioral approach.

Clinical Work & Supervision: 12 hr/wk (800 total)
Average caseload: 4 adult individuals, 1 elderly couple, and 1 child with mother. Supervision: 2 hours minimum individual supervision of case-oriented discussion weekly.

1984 - 1985

Clerkship Practicum II
Psychological Service Centre
University of Manitoba
Supervisor: Michael LeBow, Ph.D.

Individual behavioral psychotherapy focused on adult clients with severe depression. Couple therapy involved partners with extreme marital discord, communication difficulties, and sexual dysfunction. Child psychotherapy focused on reducing incidence of firestarting, and training the child's family in contracting skills.

Intake reports and clinical formulations were common. A behavioral contract was designed and set into play with the firestarting child and his family.

Clinical Work: 15 - 20 hours weekly (725 total)
Average caseload: 2 couples, 3 individual adults, and 1 child (plus family and school members of his social system).
Supervision: 2 hours minimum of individual case-oriented supervision weekly.

1982 - 1984 **Clerkship Practicum I**
Psychological Service Centre
University of Manitoba
Supervisors: Morgan Wright, Ph.D.; Joe Kuypers, Ph.D., and Walter Driedger, M.S.W.

Long term individual adult psychotherapy under the supervision of Dr. Wright using a psychodynamic approach. Two individuals began therapy in 1982 and during this time their partners and families also became involved in the therapeutic process. One of these was a severely depressed, anorexic, bulimic, self-mutilative client whose contacts with the therapist were typically of a crisis nature. The other was an individual defined by his physician as multiple personality. Additional individual adult psychotherapy supervised by Dr. Wright also involved relaxation training, communication-skills training, and contracting. Approximately 25 child and adult intellectual and personality assessments and one H-R battery neuropsychological assessment conducted.

Co-facilitation of a group focusing on interpersonal relations was supervised by Dr. Kuypers and W. Driedger. Intake reports and clinical formulations as well as systematic monitoring of the anorexic's behavior were involved.

Clinical work: 20 - 30 hours weekly (1950 total)
Average caseload: 5 adult individuals, 1 individual child, 1 couple, 2 families, and 1 group.
Supervision: 2 hours minimum of individual supervision as well as small-group case discussion weekly. One hour weekly group supervision.

CONTINUING EDUCATION:

2001 (Nov) At the **21st Annual meetings of the National Academy of Neuropsychology** in San Francisco, Nov 1-4:

3 Category 1 credits for Rationale for and Application of Short Forms
3 Category 1 credits for MMPI-2 in Neuropsychological Practice
3 Category 1 credits for The Extended Complex Figure Test
3 Category 1 credits for The Cogtest System
3 Category 1 credits for Autism and Other Pervasive Dev. Disorders
3 Category 1 credits for Assessment of Malingering

2000 (Nov) At the **20th Annual meetings of the National Academy of Neuropsychology** in Orlando, FL Nov 15-18:

3 Category 1 credits for ABPN Preparation for Board Examination. Workshop presented by Robert Elliot, et al.

3 Category 1 credits for Advances in the Neuropsycology of Epilepsy.
Workshop presented by Carl Dodrill.

1999 (Feb-May) At **Nelson Butters' West Coast Neuropsychology conference**. Advances in the Neuropsychological Assessment and Treatment of School Age Children with Cognitive Deficits. 15.0 hours Category 1 continuing Education.

Through the **National Academy of Neuropsychology distanCE Education** - Mild Traumatic Head Injury course.
30.0 hours Category 1 Continuing Education.

1999 (Jan-Apr) Through the **National Academy of Neuropsychology distanCE Education** - Neuroanatomy and Medical Neuroscience course.
30.0 hours Category 1 Continuing Education.

1998 (Feb) At the **9th Annual Meeting of the American Neuropsychiatric Association** in Honolulu, Hawaii:
14.0 hours Category 1 Continuing Education

1997 (Nov) At the **17th Annual meetings of the National Academy of Neuropsychology** in Las Vegas, NV Nov 10-13:

3 Category 1 credits for Business Aspects of Clinical Neuropsychology with particular Reference to Insurance Issues. Workshop presented by Edward A. Peck, III, Ph.D.

3 Category 1 credits for Using the MMPI-2 in Neuropsychology. Workshop presented by Lloyd I. Cripe, Ph.D. et al.

3 Category 1 credits for A Scientific Approach to forensic Neuropsychology. Workshop presented by G. Larrabee, Ph.D.

3 Category 1 credits for The WISC-III as a Neuropsychological Instrument: Update on Standardization. Workshop presented by Edith Kaplan, Ph.D

CONTINUING EDUCATION (continued):

1997 (Sept) At the **1997 Medical Symposium. Adults & Seniors with Disabilities: new Horizons for comprehensive Care** at Guam Hilton Hotel, September 13.
5.25 Contact Hours

1997 (Sept) Attended Annual Meetings of **American Association of Oral and Maxillofacial Surgeons** in Seattle, Washington September 1997.

1997 (Feb) At **8th Annual Meetings of the** American **Neuropsychiatric Association** in Orlando, FL February 2-4. 15 Category 1 credit hours

At Annual Meetings of the **International Neuropsychological Society** in Orlando, FL February 5-8

3 Category 1 credits for Ethical issues in Medicolegal Consultations.Workshop presented by Kerry des. Hamsher, Ph.D.
3 Category 1 credits for Neuropsychological Features of the WAIS-III and WMS-III. Workshop presented by David S. Tulsky, Ph.D., R. Bornstein, Ph.D. and R. Heaton, Ph.D.

3 Category 1 credits for Sick Role Susceptibility: Who Behaves Sick, Why, and What to Do. Workshop presented by Barry Blackwell, Ph.D.

1996 (Oct) At Annual Meetings of the **National Academy of Neuropsychologists** in New Orleans, LA, October 30 - Nov. 2:

6 Category 1 credits for Expert Witness Testifying Tips: Avoiding the 101 Most Common Mistakes. Workshop presented by Joseph E. Scuro, J.D.

3 Category 1 credits for Premorbid Functioning and Closed Head Injury: Clinical and Medicolegal Considerations. Workshop presented by Michael Franzen, Ph.D.

3 Category 1 credits for ABPN: Preparation for Application, Work Sample Submission and Examination for Board (Diplomat) Certification., workshop presented by Robert Elliott, Ph.D; Charles Long, Ph.D.; Barry Crown, Ph.D.; Dorrie Rapp, Ph.D.; and Cecil REynolds, Ph.D.

3 Category 1 credits for Syndrome of Nonverbal Learning Disabilities: Developmental Manifestations in Neurologic Disease, Disorder and Dysfunction, workshop presented by Byron P. Rourke, Ph.D.

CONTINUING EDUCATION (continued):

3 Category 1 credits for **The Practice of Forensic Neuropsychology**, workshop presented by Jerid Fisher, Ph.D.; Robert J. McCaffrey, Ph.D.; and Linda Laing, J.D. Esq.

1996 (July) At Annual Meetings of the **The International Council of Psychologists, Inc.**, in Banff, Alberta, CANADA:

3 Category 1 credits for Neuropsychological Evaluation of Children. Workshop

1995 (Feb.) At Annual Meetings of the **International Neuropsychological Society** in Seattle, Washington:

3 Category 1 credits for Integrating Neuropsychological and Neurosurgical Evaluations in Patients Coming to Epilepsy Surgery. Workshop presented by Carl Dodrill, Ph.D. & George Ojemann, M.D.

3 Category 1 credits for Functional Magnetic Resonance Imaging (FMRI) of the Human Brain: Methods and Applications. Workshop presented by Stephen Rao, Ph.D.

1.5 Category 1 credits for Ethical Issues in Medicolegal Consultations. Workshop presented by Kerry DeS. Hamsher, Ph.D., David Loring, Ph.D. & Wilfred van Gorp, Ph.D.

CONTINUING EDUCATION (continued):

1993 (Feb.) At Annual Meetings of the **International Neuropsychological Society** in Galveston, Texas:

1.5 Category 1 credits for Assessment and Therapy for Cognitive Deficits Following Traumatic Brain Injury. Workshop presented by Jennie Ponsford, Ph.D.

3 Category 1 credits for Autistic Spectrum Disorders Across the Life-Span. Workshop presented by Isabelle Rapin, M.D.

3 Category 1 credits for Emotional Systems in the Brain. Workshop presented by Dr. Joseph E. Ledoux.
Full day workshop on Brain Injury and Rehabilitation. Workshop chaired by Dr. Harvey Levin.

1992 (Nov.) At Annual Meetings of the **National Academy of Neuropsychology** in Pittsburgh, Pennsylvania:
3 Category 1 credits for Forensic Testimony. Workshop presented by Dr. Robert J. McCaffrey.

3 Category 1 credits for Corrections for Halstead-Reitan Battery. Advanced workshop presented by Dr. Robert K. Heaton.

(Oct.) At Annual Meetings of the **Canadian Association for Gerontology** in Edmonton, Alberta, CANADA:
Full day workshop on Dementia: Neurobiological update. Presented by Dr. Jeffrey Cummings, et al.

(Feb.) At Annual Meetings of the **International Neuropsychological Society** in San Diego, California:

3 Category 1 credits for Psychopharmacology of Aggression. Presented by Dr. Stuart C. Yudofsky.

3 Category 1 credits for Advances in Behavioral Aspects of the Dementias. Presented by Dr. Jeffrey L. Cummings.

CONTINUING
EDUCATION
(continued)

1991 (Nov.) At Annual Meetings of the **National Academy of Neuropsychology**, Dallas, TX:

3 Category 1 credits for Do Complex Motor Skills Have any Clinical Relevance? Presented by Dr. Kathleen Y. Haaland.

3 Category 1 credits for WAIS-R as a Neuropsychological Instrument (WAIS-R-NI). By Edith Kaplan.

3 Category 1 credits for The Neuropsychologist Goes to Court. Presented by Dr. Theodore H. Blau.

(June) Professional Achievement (Corporation) program on Grief, Mourning, Death, and Loss on how to effectively facilitate grief. Presented by Dr. Therese A. Rando.

At Annual meetings of the **International Neuro. Soc.**, in San Antonio, Texas:

3 Category 1 credits for Memory and the Brain: Forms of Memory and Neural Organization workshop, presented by Larry R. Squire, Ph.D.

3 Category 1 credits for Linguistic Communication Disorders of Dementing Diseases: Definition, Assessment, and Management workshop, presented by Kathryn A. Bayles, Ph.D.

1990 (Nov.) At Annual Meetings of the **National Academy of Neuropsychologists**, Reno, NV:

3 Category 1 credits for Lupus, Multiple Sclerosis and Aids workshop, presented by S. Koffler, Ph.D., Stephen Rao, Ph.D., & Frederick Schmitt, Ph.D.

3 Category 1 credits for Neurological and Psychiatric Disorders workshop, presented by Arnold Purisch, Ph.D.

6 Category 1 credits for Board Certification in Neuropsychology workshop, presented by Francis J. Fishburne, Ph.D.

1988 (Nov.) At Annual Meetings **National Academy of Neuropsychologists**, Orlando, FL:

3 Category 1 credits for Dementia workshop, presented by Nelson Butters, Ph.D.

CONTINUING EDUCATION (continued)

At Annual Meetings of **National Academy of Neuropsychologists** (continued):
3 Category 1 credits for Brain Imaging workshop, by Erin Bigler, Ph.D.

3 Category 1 credits for Integration of Neuropsychology Theory, Assessment and Cognitive Retraining workshop, presented by Ralph Reitan, Ph.D. & Deborah Wolfson, Ph.D.

3 Category 1 credits for Establishing an Independent Practice in Neuropsychology, presented by Theodore H. Blau, Ph.D.

PUBLICATIONS:

Hofer, P. (2002, Winter) What it means to be a Neuropsychologist on Guam (multicultural and professional isolation issues). Invited article in quarterly newsletter of the International Neuropsychological Society.

Bylsma, F., Ostendorf, C., & Hofer, P.(2002) Challenges in Providing Neuropsychological and Psychological Services in Guam and the Commonwealth of the Northern Marianas Islands (CNMI). Chapter in

Hofer, P. (1996). Multicultural Assessment of I.Q. Archives of Clinical Neuropsychology, 11(2).

Holborn, P. (1985). Death and Bereavement in the elderly. A teaching module prepared for the Department of Continuing Education, University of Manitoba, Module A.6.

MANUSCRIPTS IN PREPARATION:

Hofer, P., Greiner-S. Establishing Normative Data for the Woodcock Johnson-Revised Achievement Tests in a multicultural environment.

Hofer, P., Van Gorp, W., Brodsky, M., and Mahler, M. Differentiating Multi-infarct dementia from dementia of the Alzheimer's Type: A neuropsychological approach.

Hofer, P., Chaisson, C., & Babauta, E. Establishing Normative Data for C-TONI in multicultural environment.

WORKSHOP & CONFERENCE PRESENTATIONS:

Hofer, P. (2003, Oct. 24) The importance of accurate assessment after Traumatic Brain Injury. Invited speaker. Presentation at conference regarding Traumatic Brain Injury sponsored by Guam Legal Services, Inc.

Hofer, P. (2003, Oct. 18) Challenging Behaviors in Childhood. Invited speaker. Presentation at the Marriott as part of Headstart parent Training Workshop.

Hofer, P. (2003, Oct. 13) Psychological Testing on Guam: What every counsellor needs to know about intelligence, personality, and vocational evaluations. Invited speaker. Presentation made at the Multicultural Counselling (ED625) class at University of Guam.

Hofer, P. (2003, March) Understanding your pre-school child. Presentation to Guam Headstart Parent Training Workshop.

Hofer, P. (2001, April 7) Diagnosis and assessment as part of your child's I.E.P. What every parent needs to know. Presentation at G.S.A.T.. Invited speaker for Guam Legal Services, Inc.

Hofer, P. (2000, December 6) SPYS Day (Suicide Prevention in Youth services) at Benevente Middle School. Invited speaker. Presentation on symptoms of suicide and suicide prevention methods.

Hofer, P. (2000, March 19) Assessment and Treatment in a Multicultural Environment. Presentation made at the Multicultural Counselling (ED625) class at University of Guam.

Hofer, P. (1999, May 13) Dealing with Stress in Caregivers. Presentation made at the 25th annual Governor's Conference on Aging, "Honor the Past, Imagine the Future: Towards a Society for all Ages", Hilton Hotel, Guam.

Hofer, P. (1999, March 23). Human Sexuality. Presentation made to Psychology of Women class at University of Guam.

Babauta, E., Chiasson, C., & Hofer, P. (1998). Establishing Micronesian norms for psychological tests: The Computerized test of non-verbal intelligence (C-TONI).

Hofer, P. (1998, April 11 & 13). Use of Small-N designs in Human Clinical Research. Presentation made to Research Methods class at University of Guam.